4 - Rules & Regs 2237

AMENDMENT NO. 4
TO THE RESTATED PLAN DOCUMENT
AND SUMMARY PLAN DESCRIPTION
OF THE GLASSWORKERS AND GLAZIERS
HEALTH AND WELFARE FUND TRUST

Effective December 10, 2004, the Restated Plan Document and Summary Plan Description of the Glassworkers and Glaziers Health and Welfare Fund Trust are hereby amended as follows (~~strikethrough~~ text indicates a deletion, underscoring indicates an addition):

Page 40, ARTICLE II. ELIGIBILITY RULES is hereby amended by the restatement of section 2.04 Leave for Military Service under the Uniformed Services Employment and Reemployment Rights Act (USERRA) of 1994.; section 2.06 Self-Payment Provisions for Continuation Coverage. subsection f. Continuation of Health Coverage During Military Leave.; and the elimination of subsection g. Termination of Military Leave Coverage. as follows:

2.04 **Leave for Military Service under the Uniformed Services Employment and Reemployment Rights Act (USERRA) of 1994.**

a. If an Eligible Employee enters service with the Uniformed Services (as defined by USERRA) for up to thirty (30) days, his/her eligibility will continue provided the Contributing Employer makes the appropriate contributions.

b. If an Eligible Employee enters service with the Uniformed Services (as defined by USERRA) for more than thirty (30) days, his/her eligibility will terminate and he/she will be entitled to elect to continue coverage, including coverage for his/her Dependents, for up to twenty-four (24) months under section 2.06 herein.

c. If a former Eligible Employee is honorably discharged he/she will be reinstated on the day he/she returns to work with a Contributing Employer provided such individual notifies a Contributing Employer of the intent to return to work within:

1. Ninety (90) days from the date of discharge if the period of service was more than one hundred eighty (180) days; or

2. Fourteen (14) days from the date of discharge if the period of service was thirty-one (31) days or more, but less than one hundred eighty-one (181) days.

3. If the former Eligible Employee is hospitalized for or convalescing from any illness or injury caused

by active duty, the time limit to submit notice of intent to return to work with a Contributing Employer is extended to the end of the period necessary for that individual to recover, but in no case beyond two (2) years.

d. Termination of Military Leave Coverage. Continuation of coverage under USERRA will terminate on the earliest of the following dates, as applicable:

1. the end of the period for which the last payment was made for coverage in a timely manner;

2. an individual returns to work and becomes covered under this Plan; or

3. the maximum continuation period has been exhausted.

However, coverage under this Plan may continue even if the individual on military leave becomes covered under another group health plan sponsored by the Uniformed Services or the Department of Defense.

Any hours remaining in a bargaining employee's hour bank when such bargaining employee enters "service in the uniformed services" (as defined by USERRA) will be preserved until such time as he/she is discharged from "service in the uniformed services." If such individual returns to work for a Contributing Employer within the time frames provided in this section, then the employee's hour bank will be reinstated as soon as his/her eligibility is re-established. If the individual does not return to work for a Contributing Employer within the time frames identified in this section, all hours remaining in the hour bank will be forfeited to the Fund.

In the event of any conflict between this Plan and the provisions of USERRA, the provisions of USERRA will apply.

f. Continuation of Health Coverage During Military Leave.

1. If coverage under this Plan ends because of an Eligible Employee's service in the Uniformed Services as defined by USERRA ("qualified military leave"), he may elect to continue such coverage hereunder ~~COBRA~~, including coverage for his Dependents, for up to twenty-four (24) months.

2. If qualified military leave is for less than thirty-one (31) days, he will only be required to pay the same share, if any, he would pay as an Eligible Employee for that period.

3. The periods of continuation coverage under COBRA and USERRA will run concurrently. For qualified military leaves of thirty-one (31) days or more, the usual COBRA continuation coverage premium will apply.

In the event that provisions of the laws and regulations of USERRA operate in a manner which is more favorable to the employee on qualified military leave than the provisions of the laws and regulations that govern COBRA Continuation Coverage, such provisions of USERRA will control.

The following subsections are hereby relettered as follows:

~~h.~~ g. Benefit Options.

~~i.~~ h. Extension of Continuation Coverage.

Effective January 1, 2005 the Restated Plan Document and Summary Plan Description of the Glassworkers and Glaziers Health and Welfare Fund Trust are hereby amended as follows:

ARTICLE I. DEFINITIONS section 1.10 Dependent. is hereby restated as follows:

1.10 Dependent. "Dependent" means:

a. The Eligible Employees lawful spouse, which shall include only:

1. a person to whom the Eligible Employee is legally married (a marriage between a man and woman licensed, solemnized, and registered as a legal marriage); and

2. a person of the opposite sex who is not legally married to the Eligible Employee, but who cohabits with the Eligible Employee in the good faith belief such person is married to the Eligible Employee. Good faith belief shall require that the Eligible Employee and such person submit an affidavit and supporting documentation satisfactory to the ~~Administrative Office~~ Board of Trustees establishing that the Eligible Employee and such person consented to be married and that the Eligible Employee and only such person mutually assumed a martial relationship, rights, duties and obligations for at least twelve (12) continuous months prior to the execution of the affidavit. The designated agent shall review and approve the affidavit and supporting documentation on behalf of the Board of Trustees. Such affidavit and supporting documentation shall be filed with the

Administrative Office prior to the time of accrual of any benefits under the Plan by such person.

b. the Eligible Employee's unmarried children who are dependent upon the Eligible Employee for support and maintenance from birth through the end of the calendar year in which the child attains nineteen (19) years of age;

c. the Eligible Employee's unmarried children (including a stepchild or legally adopted child), are nineteen (19) to the end of the calendar year in which the child attains twenty-three (23) years of age, who are full-time students attending an accredited educational institution on a full-time basis and are dependent upon the Eligible Employee for financial support. The Fund will provide coverage for adopted children under age eighteen (18) effective as of the date of adoption or the placement of the children for adoption with the Eligible Employee in connection with adoption proceedings;

d. the Eligible Employee's unmarried Dependent children who are incapable of self-sustaining employment by reason of mental retardation or a physical handicap provided the Eligible Employee continues Dependent coverage and such incapacity commenced prior to the date the Dependent child's coverage would otherwise terminate, and provided the child is dependent upon the Eligible Employee for support and maintenance. Notification and proof of such incapacity must be submitted to the Administrative Office within thirty-one (31) days of the date of Dependent child's coverage would otherwise terminate;

e. a child shall in no event be a Dependent of another Dependent except as provided for stepchildren; and

f. Dependent children are those who reside with the eligible Employee, and who ~~satisfy all of the following:~~ maintain a parent-child relationship (including stepchildren or legally adopted children).~~, and~~

~~2. qualify as Dependents under the Internal Revenue Code, Section 152.~~

g. Dependent child also includes a child of an Eligible Employee who is designated as an alternate recipient under a qualified medical child support order (QMCSO) within the meaning of 609 of ERISA, 29 U.S.C. § 1169.

Proof of dependency status may be requested from time to time by the Board of Trustees.

ARTICLE I. DEFINITIONS section 1.46 Usual, Customary and Reasonable (UCR). is hereby restated as follows:

1.46 Usual, Customary, and Reasonable. "Usual, Customary, and Reasonable" (UCR) for Non-Preferred Providers means ~~those charges for Medically Necessary services, supplies and treatment, and shall mean the usual charges made by a Hospital, professional or other person or firm having rendered or furnished services, supplies or treatment, which do not exceed the general level of charges made by others of similar standing in the locality where the charge in incurred and which are within the maximum limits or fee schedules as adopted by the Board of Trustees~~ the Preferred Provider allowable fee established in the Metro Denver area.

With respect to Preferred Providers the term "Usual, Customary and Reasonable" means charges which the Plan has agreed to pay pursuant to the terms of an agreement between the Plan and the Preferred Provider.

With respect to Medicare Participants, the term "Usual, Customary and Reasonable" means the maximum amounts allowed by Medicare for participating and non-participating Medicare Physicians.

Pages 38-39, ARTICLE II. ELIGIBILITY RULES section 2.02 Non-Bargaining Participation. is hereby amended by the elimination of subsection g. Special Enrollment. as follows:

~~g. Special Enrollment. Special enrollment is allowed for non bargaining employees or Dependents who originally declined coverage if they:~~

~~1. had other coverage, which they later lost because of separation/divorce, termination of employment or reduction in hours, death or the cessation of employer contributions for their coverage (unless it was for cause or failure to pay employee contributions on time), or~~

~~2. were on COBRA, but their COBRA eligibility has expired.~~

~~If a Non Bargaining Employee who did not initially enroll later marries or has or adopts a child, the Non-Bargaining Employee is entitled to special enrollment along with the Dependent.~~

~~A person eligible for special enrollment has thirty (30) days from the date of the event within which to enroll, and shall become an eligible Participant on the first day of the month following receipt of the properly completed enrollment form.~~

The following subsections are relettered as follows:

~~h.~~g. Monthly Premium Payment.

~~i.~~h. Benefits.

~~j.~~i. Termination of Non-Bargaining Employees' Coverage.

~~k.~~j. Continuation of Non-Bargaining Coverage.

~~l.~~k. Reinstatement Provision.

Pages 40-42, ARTICLE II. ELIGIBILITY RULES section 2.05 Eligibility for Dependents. is hereby amended and restated as follows:

2.05 Eligibility for Dependents.

~~a. The Eligible Employee's lawful spouse, which shall include only:~~

~~1. a person to whom the Eligible Employee is legally married (a marriage between a man and woman licensed, solemnized, and registered as a legal marriage); and~~

~~2. a person of the opposite sex who is not legally married to the Eligible Employee, but who cohabits with the Eligible Employee in the good faith belief such person is married to the Eligible Employee. Good faith belief shall require that the Eligible Employee and such person submit an affidavit and supporting documentation satisfactory to the Administrative Office establishing that the Eligible Employee and such person consented to be married and that the Eligible Employee and only such person mutually assumed a martial relationship, rights, duties and obligations for at least twelve (12) continuous months prior to the execution of the affidavit. Such affidavit and supporting documentation shall be filed with the Administrative Office prior to the time of accrual of any benefits under the Plan by such person.~~

~~b. the Eligible Employee's unmarried children who are dependent upon the Eligible Employee for support and maintenance from birth through the end of the calendar year in which the child attains nineteen (19) years of age;~~

~~c. the Eligible Employee's unmarried children (including a stepchild or legally adopted child), age nineteen (19) to the end of the calendar year in which the child attains twenty three (23) years of age, who are~~

~~full-time students attending an accredited educational institution on a full time basis and are dependent upon the Eligible Employee for financial support. The Fund will provide coverage for adopted children under age eighteen (18) effective as of the date of adoption or the placement of the children for adoption with the Eligible Employee in connection with adoption proceedings;~~

~~d. the Eligible Employee's unmarried Dependent children who are incapable of self sustaining employment by reason of mental retardation or a physical handicap provided the Eligible Employee continues Dependent coverage and such incapacity commenced prior to the date the Dependent child's coverage would otherwise terminate, and provided the child is dependent upon the Eligible Employee for support and maintenance. Notification and proof of such incapacity must be submitted to the Administrative Office within thirty-one (31) days of the date of Dependent child's coverage would otherwise terminate;~~

~~e. a child shall in no event be a Dependent of another Dependent except as provided for stepchildren; and~~

~~f. Dependent children are those who reside with the Eligible Employee, and who satisfy all of the following:~~

~~(a) maintain a parent-child relationship (including stepchildren or legally adopted children), and~~

~~(b) qualify as Dependents under the Internal Revenue Code, Section 152.~~

~~g. Dependent child also includes a child of an Eligible Employee who is designated as an alternate recipient under a qualified medical child support order (QMCSO) within the meaning of 609 of ERISA, 29 U.S.C. § 1169.~~

~~Proof of dependency status may be requested from time to time by the Board of Trustees.~~

a. Eligibility Date. The eligibility date with respect to any Dependent shall be determined as follows:

1. if an Eligible Employee has any Dependents on the date he becomes eligible for coverage under the eligibility rules, Dependents shall become eligible on the same date; or

2. if an Eligible Employee acquires a Dependent after that date, the Dependent spouse shall become eligible on the date of marriage. A Dependent

child, who is within the applicable age limits stated in the definition of Dependent shall become eligible on the date acquired.

b. Effective Date of Dependent Coverage. The coverage, with respect to an Eligible Employee's Dependent, shall become effective on the date the Dependent becomes eligible, except that no benefits are to be paid for days of hospitalization which occur prior to the effective date or for medical or surgical services rendered prior to that date.

c. Effective Date of Health Insurance for Newborn Children. A child born to an Eligible Employee will automatically become covered as a Dependent. The effective date of coverage for the child will be that date of birth. Coverage will be to the same as is provided for other covered Dependent children.

d. Termination of Dependent Eligibility. The eligibility, with respect to a Dependent, shall automatically terminate upon the occurrence of the first of the following events:

1. when the Dependent ceases to be eligible as a Dependent as set forth under the definition of Dependent. Such Dependent may elect to continue coverage under section 2.06;

2. when the Eligible Employee's eligibility terminates for any reason. Such Dependent may be entitled to continue coverage under section 2.06;

3. the date the Dependent enters full-time military service;

4. the date of death.

Pages 47-48, ARTICLE II. ELIGIBILITY RULES is hereby amended by the addition of section 2.07 Special Enrollment., section 2.08 Certification of Coverage When Coverage Ends. and section 2.09 Procedure for Requesting and Receiving a Certificate of Creditable Coverage. as follows:

2.07 Special Enrollment. Special enrollment is allowed for Eligible Employees or Dependents who originally declined coverage if:

a. they had other health benefit coverage, which they later lost because of legal separation, divorce, termination of employment or reduction in hours, death, or the cessation of employer contributions for their coverage (unless it was for cause or failure to pay employee contributions on time);

b. they were on COBRA, but their COBRA eligibility has expired;

c. they moved out of an HMO service area and HMO coverage terminated for that reason, and for group coverage, no other option is available under the other plan;

d. the other plan ceases to offer coverage to a group of similarly situated individuals which includes the Eligible Employee and Dependents;

e. they lose dependent status under the other plan's terms;

f. the other plan terminates a benefit package option, unless substitute coverage is offered;

g. the loss of eligibility is due to reaching the lifetime maximum on all benefits under the other plan. For special enrollment that arises from reaching a lifetime benefit maximum on all benefits, an individual must request enrollment in this Plan within thirty-one (31) days after a claim is denied by the other plan due to operation of a lifetime maximum limit on all benefits.

If an Eligible Employee who did not initially enroll later marries or has or adopts a child, the Eligible Employee is entitled to special enrollment along with the Dependent (and other Dependents).

A person eligible for special enrollment must request such enrollment within thirty-one (31) days from the date of the event and shall become an eligible Participant on the first day of the month following receipt of the properly completed application form, subject to administrative approval. Individuals that enroll under special enrollment have the same benefit options, same cost, and same enrollment requirements as other similarly situated individuals.

2.08 **Certification of Coverage When Coverage Ends.** When coverage ends, Participants are entitled by law to, and will be provided (free of charge) with a Certificate of Coverage that indicates the period of time such individuals were covered under the Plan. Such a certificate will be provided within a reasonable time after the Plan knows or has reason to know that coverage has ended.

2.09 **Procedure for Requesting and Receiving a Certificate of Creditable Coverage.** A certificate will be provided within a reasonable time after receipt of a written request for such a certificate that is received by the Administrative Office within two (2) years after the date coverage ended under this Plan. The written request must be mailed

(faxed, or e-mailed) to the Administrative Office and should include the name of the individuals for whom a certificate is requested (including spouse and dependent children) and the address where the certificate should be mailed. A copy of the certificate will be mailed by the Plan to the address indicated.

Page 80, ARTICLE VII. GENERAL PROVISIONS is hereby amended by the addition of section 7.18 Use and Disclosure of Protected Health Information (PHI). as follows:

7.18 Use and Disclosure of Protected Health Information (PHI). The Plan will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Health Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

a. Payment. Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

1. determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, Plan maximums and copayments as determined for an individual's claim);

2. coordination of benefits;

3. adjudication of health benefit claims (including appeals and other payment disputes);

4. subrogation of health benefit claims;

5. establishing employee contributions;

6. risk adjusting amounts due based on enrollee health status and demographic characteristics;

7. billing, collection activities and related health care data processing;

8. claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to Participant inquiries about payments;

9. obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

10. medical necessity reviews or reviews of appropriateness of care or justification of charges;

11. utilization review, including precertification, preauthorization, concurrent review and retrospective review;

12. disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health Plan); and

13. reimbursement to the Plan.

b. Health Care Operations. Health care operations include, but are not limited to, the following activities:

1. quality assessment;

2. population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contracting health care providers and patients with information about treatment alternatives and related functions;

3. rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;

4. underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);

5. conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

6. business planning and development, such as conducting cost-management and planning related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;

7. business management and general administrative activities of the Plan, including, but not limited to:

   (a) management activities relating to the implementation of and compliance with HIPAA's Administrative Simplification requirements, or

   (b) customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;

   (c) resolution of internal grievances; and

   (d) due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity under HIPAA or, following completion of the sale or transfer, will become a covered entity.

8. Compliance with and preparation of all documents as required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500's, SAR's, and other documents.

c. The Plan Will Use and Disclose PHI as Required by Law and as Permitted by Authorization of the Participant or Beneficiary. With a written authorization, the Plan will disclose PHI to another benefit plan for purposes related to administration of that plan.

d. For Purposes of This Section the Board of Trustees Is the Plan Sponsor. The Plan shall disclose PHI to the Plan Sponsor for the purpose of deciding health claim appeals. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions.

e. With Respect to PHI, the Plan Sponsor Agrees to Certain Conditions. The Sponsor agrees to:

   1. not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;

   2. ensure that any agents or independent contractors, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

3. not use or disclose PHI for employment-related actions and decisions unless authorized by the individual;

4. not use or disclose the information in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the individual;

5. report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided of which it becomes aware;

6. make PHI available to an individual in accordance with HIPAA's access requirements;

7. make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

8. make available the information required to provide an accounting of disclosures;

9. make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and

10. if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.

f. Adequate Separation Between the Plan and the Plan Sponsor Must Be Maintained. In accordance with HIPAA, only the Board of Trustees, other Plan contracted Covered Entities and Business Associates may be given access to PHI.

g. Limitations of PHI Access and Disclosure. The persons described in section f. may only have access to and use and disclose PHI for plan administration functions that the Plan Sponsor performs for the Plan. If the persons described in section f. do not comply with this Plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

h. Security Rule Compliance. The Plan Sponsor will:

1. implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the group health plan,

2. ensure that the adequate separation discussed in f. above, specific to electronic PHI, is supported by reasonable and appropriate security measures,

3. ensure that any agent or independent contractor, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and

4. report to the Plan any security incident of which it becomes aware concerning electronic PHI.

Effective July 1, 2005 the Restated Plan Document and Summary Plan Description of the Glassworkers and Glaziers Health and Welfare Fund Trust are hereby amended as follows:

ARTICLE V. GENERAL EXCLUSIONS AND LIMITATIONS section 5.01 General Exclusions and Limitations. is hereby amended by the restatement of subsection 11. as follows:

11. Charges for services or supplies resulting from injuries suffered by a Participant in ~~an automobile~~ a motor vehicle (including motorcycles) accident up to $10,000 or such higher amount as may be available for reimbursement to a Participant under ~~automobile~~ motor vehicle medical payment insurance coverage, whether or not the Participant has such coverage.

ARTICLE VI. COORDINATION OF BENEFITS section 6.01 Coordination of Benefits. is hereby amended by the restatement of subsection b. Automobile Insurance. as follows:

b. ~~Automobile~~ Motor Vehicle Insurance. Benefits under This Plan will be coordinated, after the exclusion of $10,000 in charges or such higher amount as may be available as described in section 5.01, 11., with a Participant's ~~automobile~~ motor vehicle medical payments

coverage or with any other ~~automobile~~ motor vehicle insurance applicable to the state in which the Participant resides and is insured.

The Chairman and Secretary of the Board of Trustees of the Glassworkers and Glaziers Health and Welfare Fund Trust do hereby certify that the foregoing Amendment was duly adopted at a meeting held on June 2, 2005.

Chairman

Secretary J. SIGMAN

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